Cruzan’s Legacy in Autonomy

Kathy L. Cerminara
Nova Southeastern University, Shepard Broad College of Law, cerminar@nova.edu

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Kathy L. Cerminara*

TABLE OF CONTENTS

I. INTRODUCTION ........................................ 27
II. FROM NUTRITION AND HYDRATION TO FOOD AND WATER ............................................ 29
III. FROM PERSISTENT VEGETATIVE STATE TO MINIMALLY CONSCIOUS STATE ...................... 33
IV. FROM DENIAL OF DEATH TO PROTESTS AGAINST ONE TYPE OF DEATH ................................. 39
   A. DEATH AS A SOCIAL CONSTRUCT ..................... 40
   B. PUSHBACK AGAINST BRAIN DEATH DECLARATIONS .. 41
V. CONCLUSION ........................................... 46

I. INTRODUCTION

The Supreme Court in Cruzan v. Director, Missouri Department of Health1 effectively enshrined personal autonomy in a medical setting as a constitutionally protected liberty interest. Although the majority opinion only “assumed” the right’s existence,2 Justice O’Connor, writing in concurrence, and four other Justices writing in dissent explicitly found that the right existed.3 In a later opinion about medical decision-making, the Court described itself as having “assumed, and strongly suggested” the right’s existence in Cruzan.4 Certainly, the majority opinion stated in dicta that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,”5 thus laying a solid foundation upon which to base a conclusion that such a constitutionally protected liberty interest existed.

The various opinions in Cruzan, however, disagreed about the shape and boundaries of the right. In the case’s immediate aftermath, the federal-ly recognized right to exercise autonomy in medical decision-making

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* Professor of Law, Nova Southeastern University, Shepard Broad College of Law.
The author thanks her research assistant, Erin Peduzzi, for excellent work on this article.
2. Id. at 279.
3. Id. at 287, 289 (O’Connor, J., concurring); id. at 302 (Brennan, J., dissenting, joined by Marshall and Blackmun, JJ.); id. at 331 (Stevens, J., dissenting).
5. Cruzan, 497 U.S. at 278 (majority opinion) (characterizing this statement as dicta); see also ALAN MEISEL ET AL., THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISION-MAKING § 2.03[A][2], at 2-10 (3d ed. 2004).
faced two divergent paths. The majority and Justice O’Connor’s concur-
renee spoke of the right as rooted in the common-law doctrine of in-
formed consent, and the Supreme Court later, in Washington v. Glucksberg, echoed that approach. In contrast, Justice Stevens, writing in concurrence, envisioned a more expansive view of autonomy, one that not only encompassed a right to say “no” to bodily intrusion, but also honored the right to say “yes”—to make decisions regarding one’s body and the condition in which one would wish to live. The latter conception of the right is more true to the origins of the doctrine of informed consent upon which the majority relied, given that the roots of informed consent grew from a desire to ensure patients’ receipt of adequate knowledge to make decisions, both affirmative and negative.

Since Cruzan, the right to personal autonomy in decision-making has continued to develop along both paths. In Glucksberg, the Supreme Court considered it a right to say “no,” based on Justice O’Connor’s conception in Cruzan, but it did so by rephrasing the right as something other than medical decision-making. Glucksberg involved claims by physicians and terminally ill patients that state laws prohibiting assisted suicide were unconstitutional when applied to terminally ill patients with decision-making capacity who sought prescriptions to cut short their dying processes. The Court did not even consider the case before it as involving a right to make medical decisions; the majority decided the case by examining whether a federal constitutional “right to suicide” existed. Cruzan and Glucksberg represent the extent to which the Court has addressed end-of-life medical decision-making, but other courts since have recognized a more expansive conception of autonomy than the one recognized by the Cruzan majority.

The Supreme Court has adopted the more inclusive view of autonomy in other areas of constitutionally protected decision-making since Cruzan. In United States v. Windsor, the Court held unconstitutional the federal Defense of Marriage Act, whose effects it said were “to demean” those

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6. Cruzan, 497 U.S. at 277 (majority opinion); id. at 287 (O’Connor, J., concurring); id. at 293 (Scalia, J., concurring); see also Glucksberg, 521 U.S. at 725 (describing Cruzan as establishing no general “right to die” “deduced from abstract concepts of personal autonomy”); id. at 727 (rejecting proposition that citizens have protected liberty interests in “all important, intimate, and personal decisions”).

7. See Glucksberg, 521 U.S. at 799 (Stevens, J., concurring); see also Meisel et al., supra note 5, § 2.03[B], at 2-13.

8. As Justice Cardozo explained in 1914, “Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .” Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

9. Glucksberg, 521 U.S. at 705-09 (majority opinion).

10. Id. at 723.


13. Id. at 751–52.
it affected.\textsuperscript{14} A law with “the power to degrade or demean” those it affected was unconstitutional as a deprivation of the constitutional interest in personal liberty.\textsuperscript{15} In Obergefell v. Hodges,\textsuperscript{16} the Court similarly struck down states’ refusals to recognize gay marriage. The Court held the state statutes at issue to be unconstitutional as violations of the constitutional liberty to make “certain personal choices.”\textsuperscript{17} It held that the Constitution protected the decision to marry because that decision “is among life’s momentous acts of self-definition.”\textsuperscript{18} The right the Supreme Court protected in both Windsor and Obergefell was the right to make “certain personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs.”\textsuperscript{19}

This article considers the Court’s divergent paths of analysis with respect to three types of end-of-life medical decision-making occurring more and more frequently as medical knowledge grows. It addresses three areas in which clinical boundaries have moved since the time of Cruzan, each of which will help define autonomy to make end-of-life medical decisions in the future. Surrogate refusal of medically supplied nutrition and hydration was at issue in Cruzan and now is well-accepted; surrogate refusal of food and water administered by mouth is coming. Cruzan involved surrogate refusal of end-of-life treatment of a patient in a persistent vegetative state (PVS), now well-accepted. Issues increasingly will arise regarding surrogate refusal of such treatment when a patient is in a minimally conscious state (MCS). Finally, at the time of Cruzan, it generally appeared that “death is death.”\textsuperscript{20} Now, clinicians are facing increasing surrogate decisions blocking the removal of brain-dead patients (patients dead by neurological criteria) from maintenance.

II. FROM NUTRITION AND HYDRATION TO FOOD AND WATER

One important facet of Cruzan was that the medical treatment Ms. Cruzan’s family sought to withdraw was medically supplied nutrition and hydration administered through a PEG tube directly into Ms. Cruzan’s body. In re Quinlan,\textsuperscript{21} the seminal case involving the right to refuse life-sustaining treatment, and many other similar cases involved removal of

\begin{itemize}
\item \textsuperscript{14} Id. at 774.
\item \textsuperscript{15} Id.
\item \textsuperscript{16} 135 S. Ct. 2584 (2015).
\item \textsuperscript{17} Id. at 2597.
\item \textsuperscript{18} Id. at 2599 (quoting Goodridge v. Dep’t of Pub. Health, 798 N.E.2d 941, 955 (Mass. 2003)).
\item \textsuperscript{20} See Alice D. Ackerman, Death is Death: Isn’t It?, 45 CRITICAL CARE MED. 1579, 1579–80 (2017).
\item \textsuperscript{21} 355 A.2d 647 (N.J. 1976).
\end{itemize}
respirators, and a respirator is readily understood to be life-sustaining treatment. In contrast, the Court in *Cruzan* had to decide whether medically supplied nutrition and hydration was life-sustaining treatment. Although many pre-*Cruzan* courts had considered it to be medical treatment capable of being withheld or refused, *Cruzan* provided an opportunity to learn whether the Supreme Court agreed. Five Justices did agree, affirming the predominant secular view of the matter.

For example, Justice O’Connor wrote: “I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, and that the refusal of artificially delivered food and water is encompassed within that liberty interest.” She further explained that “[a]rtificial feeding cannot readily be distinguished from other forms of medical treatment.” While focusing primarily on the degree of bodily invasion medically supplied nutrition and hydration causes rather than on precise classification as treatment, she nevertheless concluded that “the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment, including the artificial delivery of food and water.”

Justice Brennan explicitly addressed why medically supplied nutrition and hydration constituted medical treatment. While he wrote in dissent from the Court’s holding, he, Justice Marshall, and Justice Blackmun, who joined his opinion, were three of the five Justices constituting a majority that concluded that medically supplied nutrition and hydration was medical treatment. Brennan explained:

> The artificial delivery of nutrition and hydration is undoubtedly medical treatment. The technique to which Nancy Cruzan is subject—artificial feeding through a gastrostomy tube—involves a tube implanted surgically into her stomach through incisions in her abdomen.

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22. Id. at 655.
23. *Meisel et al.*, supra note 5, § 6.03[E], at 6-64 (describing ventilators, commonly called respirators, as “devices that assist patients in breathing”).
24. See id. § 6.03[G][5], tbl. 6-82.4-6-82.8 (listing cases, many both before and after *Cruzan*, involving medically supplied nutrition and hydration).
27. *Cruzan*, 497 U.S. at 287 (O’Connor, J., concurring) (citation omitted).
28. Id. at 288 (citing Council on Ethical and Judicial Affairs, Am. Med. Ass’n, Ethical Op. 2.20, Withholding or Withdrawing Life-Prolonging Medical Treatment 13 (1989); Nancy Berlinger et al., The Hastings Ctr., Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 59 (1987)).
29. Id. at 289 (emphasis added).
Artificial delivery of food and water is regarded as medical treatment by the medical profession and the Federal Government. According to the American Academy of Neurology: “The artificial provision of nutrition and hydration is a form of medical treatment... analogous to other forms of life-sustaining treatment, such as the use of the respirator. When a patient is unconscious, both a respirator and an artificial feeding device serve to support or replace normal bodily functions that are compromised as a result of the patient’s illness.” The Federal Government permits the cost of the medical devices and formulas used in enteral feeding to be reimbursed under Medicare. The formulas are regulated by the federal Food and Drug Administration as “medical foods,” and the feeding tubes are regulated as medical devices.30

The colloquial, non-technological, “non-treatment” analog to medically supplied nutrition and hydration is food and water. Today, a patient with decision-making capacity is widely recognized as having the right to voluntarily refuse food and water by mouth when he or she nears death.31 For example, a late-stage cancer patient with decision-making capacity can not only refuse all chemotherapy and other potentially curative treatments, but can also refuse all attempts to feed him or her by mouth until he or she expires, likely through dehydration rather than starvation.32

This contrasts markedly with the way Justice Scalia viewed food and water in Cruzan. He made plain in his concurrence his view that a person, even an ill one, refusing food and water could be force-fed; otherwise, the person would be committing suicide.33 Now, however, medical ethicists concur that a person with capacity cannot be force-fed if there is a medical reason for the refusal.34 Even a prisoner can refuse all nutrition and hydration, medically supplied or not, if doing so for reasons of illness.35 State interests may outweigh a prisoner’s right to refuse if the prisoner is refusing food and water as a protest or an attempt to obtain some special

30. Id. at 307–08 (Brennan, J., dissenting) (citations omitted).
33. Cruzan, 497 U.S. at 293 (Scalia, J., concurring).
34. Menzel, supra note 31, at 636 (explaining that, at one time, it was likely that the person refusing food and water would be deemed to lack decision-making capacity despite the existence of solid arguments that he or she did not lack such capacity).
35. MEISEL ET AL., supra note 5, § 5.04[F][1].
treatment, but they will not outweigh it if the reason the prisoner is refusing food and water is the proximity of death.\textsuperscript{36}

This is recognition of people as masters of their own destiny, as being truly able to control the ends of their lives. Withholding or withdrawal of medically supplied nutrition and hydration and voluntarily stopping eating and drinking both involve the right to say “no,” so some might consider both to represent informed-consent-based autonomy in decision-making. Only one, however, involves a refusal of \textit{treatment}. Whereas the Court in \textit{Cruzan} determined whether Ms. Cruzan’s parents were refusing treatment to determine whether there was a constitutional right to refuse, clinicians today recognize the rights of patients with capacity to refuse even food and water, which do not constitute medical treatment. What is at issue is not a right to refuse medical treatment, but a right to make a decision to control the end of life. Because patients without capacity retain the same constitutional rights as patients with capacity,\textsuperscript{37} surrogates must be able to exercise incapacitated patients’ rights to refuse food and water by mouth.\textsuperscript{38}

In fact, now that clinicians frequently honor voluntary refusals of food and water by patients with capacity, some patients, especially those with Alzheimer’s Disease diagnoses, are writing advance directives refusing food and water by mouth when they reach late-stage dementia.\textsuperscript{39} States may attempt to assert state interests to limit the exercise of such a right, as they do in some cases involving prisoners with decision-making capacity, but Justice O’Connor provided some insight into whether those assertions will be constitutional. In her concurrence, she emphasized that the Court in \textit{Cruzan} did not “decide the issue whether a State must also give effect to the decisions of a surrogate decision-maker. In my view, such a duty may well be constitutionally required to protect the patient’s liberty interest in refusing medical treatment.”\textsuperscript{40} The execution of an advance directive evidencing the patient’s choice of surrogate decision-maker, she said,

may be a valuable additional safeguard of the patient’s interest in directing his medical care. Moreover, as patients are likely to select a family member as a surrogate, giving effect to a proxy’s decisions

\textsuperscript{36} Id. § 5.04[F][1], at 5-60.

\textsuperscript{37} Id. § 2.05, at 2-18 (“[T]here is still more than a grain of truth to that view . . . .”).

\textsuperscript{38} See \textit{Cruzan}, 497 U.S. at 273 (majority opinion) (describing \textit{Quinlan} as “[r]easoning that the right of self-determination should not be lost merely because an individual is unable to sense a violation of it”).


\textsuperscript{40} \textit{Cruzan}, 497 U.S. at 289 (O’Connor, J., concurring) (citation omitted).
may also protect the “freedom of personal choice in matters of... family life.”

Thus, she instructed that the Court’s decision in Cruzan did “not preclude a future determination that the Constitution requires the States to implement the decisions of a patient’s duly appointed surrogate.” Justice O’Connor in Cruzan provided a blueprint for arguing that it would be unconstitutional to prevent a patient’s appointed surrogate decision-maker from refusing food and water by mouth on the patient’s behalf.

III. FROM PERSISTENT VEGETATIVE STATE TO MINIMALLY CONSCIOUS STATE

No one involved in Cruzan, including her guardian ad litem, questioned whether Nancy Cruzan was in a PVS. The same was true of Karen Ann Quinlan at the time of her seminal case on withdrawing or withdrawal of life-sustaining treatment in 1976. Trust in medical professionals may not have been as complete as it was before the development of informed consent as a legal doctrine, but no one disputed those diagnoses. Indeed, the trial court in Cruzan found, “and no party contested, that Nancy [had] no possibility of recovery and no consciousness.”

At the time of Cruzan, medical professionals—at least those involved in that lawsuit—thought they understood the PVS. Based on uncontradicted medical evidence, the Supreme Court majority in Cruzan described the PVS as “a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function.” Justice Brennan described Ms. Cruzan’s “irreversible persistent vegetative

41. Id. at 291–92 (citation omitted) (quoting Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639 (1974)).
42. Id. at 292.
43. COLBY, supra note 26, at 135 (Ms. Cruzan’s guardian ad litem sided with her legal team); see also Joseph T. Giacino, The Vegetative and Minimally Conscious States: Consensus-Based Criteria for Establishing Diagnosis and Prognosis, 19 NEUROREHABILITATION 293, 294 (2004) [hereinafter Giacino, The Vegetative and Minimally Conscious States] (a person in a PVS has suffered devastation of the cerebral cortex (otherwise known as the higher brain) but his or her brainstem continues functioning, enabling such actions as reflex motions and sleep-wake cycles).
46. Cruzan, 497 U.S. at 345 (Stevens, J., dissenting).
47. Dr. Ronald Cranford examined the patients and testified in many cases about withholding or withdrawal of life-sustaining treatment with respect to patients in a PVS. Ivan Oransky, Obituary: Ronald E. Cranford, 368 LANCET 112 (2006); see also Steven H. Miles, Ronald Cranford, MD, a Leading Neurologist on Coma and Unconsciousness, Dies at 65, MEDSCAPE, https://www.medscape.com/viewarticle/533952 [https://perma.cc/N8J8-EBBF] (last visited Feb. 19, 2020).
48. Cruzan, 497 U.S. at 261 (majority opinion).
“state” as “a twilight zone of suspended animation where death commences while life, in some form, continues.” He said Ms. Cruzan was “oblivious to her surroundings and [would] remain so.”

Her body twitches only reflexively, without consciousness. The areas of her brain that once thought, felt, and experienced sensations have degenerated badly and are continuing to do so. The cavities remaining are filling with cerebro-spinal fluid. The “cerebral cortical atrophy is irreversible, permanent, progressive and ongoing.”

In short, he said, “Nancy will never interact meaningfully with her environment again.”

That much is still true; it would be difficult to find a medical professional to opine that a patient in an irreversible PVS for more than seven years (as Ms. Cruzan was) had any chance of future meaningful interaction with her environment. Modern neurology has determined that a vegetative state (VS), which should not be diagnosed until one month post-injury, should not be categorized as “persistent” or “permanent.” Instead, temporal characteristics determine when the VS is considered to be permanent; the temporal dividing line is twelve months after a traumatic brain injury and three months after a nontraumatic (hypoxic-ischemic) brain injury. Many state statutes listing the PVS as a physical triggering condition for advance directives use the term “irreversible” in conjunction with “persistent vegetative state” to express the same concept.

Some families of patients in the irreversible PVS, however, cling to hope well beyond those time frames. Widespread publicity of “miracle

49. Id. at 303 (Brennan, J., dissenting).
50. Id. at 301 (quoting Rasmussen v. Fleming, 741 P.2d 674, 678 (1987) (en banc)).
51. Id.
52. Id. (quoting Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988)).
53. Id. (quoting Cruzan, 760 S.W.2d at 422).
55. Id. at 294.
56. Id.
57. Id. at 295 (explaining that after a traumatic brain injury (TBI), remaining in a VS for more than one year (twelve months) is permanent, and after non-TBI (hypoxic-ischemic injury), three months constitutes permanence); see also James L. Bernat, Chronic Consciousness Disorders, 60 ANN. REV. MED. 381, 386 (2009); Carol E. Fisher & Paul S. Appelbaum, Diagnosing Consciousness: Neuroimaging, Law, and the Vegetative State, 38 J.L. MED. & ETHICS 374, 377 (2010) (noting broadly that many state statutes “typically contain quasi-operationalized definitions of ‘permanent unconsciousness’ or VS, which often do not correspond to the current clinical understanding of these diagnoses”); Multi-Society Task Force on PVS, Medical Aspects of the Persistent Vegetative State (First of Two Parts), 330 NEW ENG. J. MED. 1499, 1499 (1994). A hypoxic-ischemic injury is one that is nontraumatic, with neurons in the brain being damaged from lack of oxygen. Bernat, supra, at 386.
58. For example, Florida’s statutory definition of “persistent vegetative state” is “a permanent and irreversible condition of unconsciousness in which there is: (a) [the absence of voluntary action or cognitive behavior of any kind]; [and] (b) [an inability to communicate or interact purposefully with the environment].” FLA. STAT. ANN. § 765.101(15) (West 2015).
recoveries” fuel denial and increasingly vocal pro-life activists often support that denial. Diagnoses of PVS have become a bit more controversial since Cruzan, as exemplified by a famous series of cases and legislative action involving Theresa Marie Schiavo, which concluded almost thirty years after Quinlan and fifteen years after Cruzan.

Ms. Schiavo had been found unresponsive in her home at the age of twenty-seven, apparently as a result of a cardiac arrest depriving her brain of oxygen and leaving her in a PVS. Despite intensive treatment including an experimental thalamic implant, Ms. Schiavo remained in a PVS three years later, when her parents and her husband began to disagree about her care. Her husband, Michael Schiavo, believed that Ms. Schiavo would want to stop life-sustaining treatment, while her parents wanted treatment to continue. Although it initially seemed as if her parents agreed with medical experts and the court that Ms. Schiavo lay in a PVS, they began to question that diagnosis during the ongoing dispute. For the next seven years, through litigation, legislation, and governmental agency action, Ms. Schiavo’s parents argued that she was partially aware, claiming that she was in a minimally conscious state (MCS), although they did not use that terminology.

The MCS differs significantly from the PVS, not only medically, but also legally. Medically, the MCS’s name reveals the major difference. Whereas patients in the PVS are not conscious at all, patients in the MCS have some level of consciousness ranging from MCS-minus (barely conscious) to MCS-plus (fully conscious).
conscious) to MCS-plus (some activity and possible interaction). Legally, the fact that consciousness exists has led courts thus far to review requests for withholding or withdrawal of life-sustaining treatment in MCS-patient cases far more stringently than in PVS-patient cases.

Ms. Schiavo’s parents were arguing that she was in an MCS rather than the PVS. Late in the series of conflicts characterizing the case, they submitted affidavits claiming that Ms. Schiavo had uttered intelligible words: “I want to live.” Ms. Schiavo’s autopsy later revealed that she could not have been as aware as her parents had argued. Her brain weighed only 615 grams (1.35 pounds), which was less than half the weight expected in a person her size. She was cortically blind, thus unable to follow objects or make eye contact with others, as her parents had argued. While an autopsy cannot determine whether a person was in a PVS before death, her autopsy could and did demonstrate that the physical portions of her brain necessary for consciousness simply were not present.

In cases involving patients with less brain damage, however, this scientific progress since Cruzan has done more than its fair share of encouraging fears and denial with regard to withholding and withdrawing life-

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68. See, e.g., In re Wendland, 28 P.3d 151 (Cal. 2001); In re Martin, 538 N.W.2d 399 (Mich. 1995); In re Edna M.F., 563 N.W.2d 485 (Wis. 1997).


72. Letter from Stephen J. Nelson, Chief Med. Exam’r, 10th Judicial Circuit of Fl.a., to J.R. Thogmartin, Chief Med. Exam’r, 6th Judicial Circuit of Fl.a. 5, available at https://bioethics.miami.edu/assets/pdf/ethics/Documents/documents/schivo/061505-autopsy.pdf [https://perm.cc/3T3F-TL5J] (“The decedent’s brain was grossly abnormal and weighed only 615 grams (1.35 lbs.). That weight is less than half of the expected tabular weight for a decedent of her adult age of 41 years 3 months 28 days. By way of comparison, the brain of Karen Ann Quinlan weighed 855 grams at the time of her death, after 10 years in a similar persistent vegetative state.”).

73. Id. at 8.

74. Id. at 6, 8; Ronald Cranford, Commentary, Facts, Lies, and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo, 33 J.L. MED. & ETHICS 363, 369 (2005) (describing a “strategy of misinformation” involving the use of videotapes originally created to assist the courts in understanding Ms. Schiavo’s condition “to mislead much of the media and public into believing that Terri could meaningfully and cognitively interact with her parents and thus was not in a vegetative state”); see also Ronald E. Cranford, A Common Uniqueness: Medical Facts in the Schiavo Case, in THE CASE OF TERRI SCHIAVO: ETHICS, POLITICS, AND DEATH IN THE 21ST CENTURY 112–13 (Kenneth W. Goodman ed., 2010).
sustaining treatment. Disorders of consciousness, as neurologists term both the PVS and the MCS, are complex and poorly explained—if explained at all—in sound bites. Yet, sound bites are what families and friends have in mind when they discuss their loved ones’ conditions with physicians and other medical personnel.

Today, diagnosis of a patient in an irreversible PVS as opposed to the MCS changes the legal analysis of end-of-life decision-making. Courts considering requests for withholding or withdrawal of life-sustaining treatment from patients in MCS have been stringent in requiring evidence to support claims that the patients would have wished to refuse that treatment.75 Were the courts to treat patients in PVS as they have treated patients in the MCS thus far, it would be far more difficult for their loved ones to free them from their prisons in a “twilight zone.”76

Those were cases in which patients had not executed written advance directives, leaving their families to make decisions for them by operation of law rather than patient designation.77 One might think that patients designating surrogate decision-makers would be better off, especially if recalling Justice O’Connor’s instructions in Cruzan that the Constitution likely requires that clinicians and courts honor an appointed surrogate decision-maker’s decisions.78 To the contrary, however, a patient who has left a written advance directive specifying a surrogate decision-maker may inadvertently cause problems for himself or herself because of state statutes purporting to limit the situations in which that advance directive becomes effective.79

Statutes in all states incorporate triggering conditions to limit the circumstances under which advance directives become effective. One common nonphysical limitation is that the advance directive is not effective unless a patient has lost decision-making capacity.80 In addition to requiring incapacity, many statutes require that patients lie in specified physical conditions. The PVS is a common physical triggering condition, but no state statute lists the MCS as a physical triggering condition.81

Regardless of which view of autonomy governs, previous work has demonstrated that narrowly construing statutes to limit the right to patients in the PVS would violate the Constitution.82 Under either approach to autonomy, no state interests justify a state’s imposition of continued

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75. See, e.g., In re Wendland, 28 P.3d 151, 166 (Cal. 2001).
77. See Wendland, 28 P.3d at 156; In re Martin, 538 N.W.2d 399, 411 (Mich. 1995); In re Edna M.F., 563 N.W.2d 485, 491 (Wis. 1997).
78. Cruzan, 497 U.S. at 289 (O’Connor, J., concurring).
80. MEISEL ET AL., supra note 5, § 7.
81. Cerminara & Kadis, supra note 66, at 89.
82. Id. at 86–87.
treatment of a patient who will die relatively soon when that patient is in a condition he or she finds unbearable.\textsuperscript{83}

Diagnosis as being in the MCS or the PVS does, however, greatly affect the substantive factors the surrogate decision-maker should examine in determining whether a patient would have chosen to terminate treatment in the condition at hand. A patient in a PVS has no cognition; he or she is experiencing no life.\textsuperscript{84} As Justice Brennan in\textit{ Cruzan} noted,

\textit{[T]reatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible.\textsuperscript{85}}

Thus, reliance on a patient’s perception of pain or anything else is inappropriate in cases of patients in the PVS. Although Justice Scalia described the petitioners in\textit{ Cruzan} as arguing that Ms. Cruzan was “permanently incapacitated and in pain,”\textsuperscript{86} the descriptions written by the rest of the Justices are more accurate. A patient in a PVS would not experience pain.\textsuperscript{87} A patient in the MCS, however, might experience pain or contemporaneous interactions at the bedside; indeed that is the type of clinical evidence that would be used to determine that they were in the MCS rather than the PVS.\textsuperscript{88} To the extent it seems reliable, their consciousness must be a part of the decision-making calculations.\textsuperscript{89}

Considering a patient’s likely experience in the MCS merely adds to the evidentiary possibilities; it does not rule out withholding or withdrawal of life-sustaining treatment. Many patients with decision-making capacity, such as those who refuse chemotherapy, are conscious when refusing life-sustaining treatment.\textsuperscript{90} Patients who choose medical aid-in-dying are fully conscious—indeed, they must be fully conscious—at the time they end their lives.\textsuperscript{91} Being conscious of one’s existence does not mean being content within that existence; it may mean more of a desire to end

\textsuperscript{83. Id.}
\textsuperscript{84. One possible exception may be if covert consciousness becomes well-accepted as occurring. Joseph J. Fins & James L. Bernat, Ethical, Palliative, and Policy Considerations in Disorders of Consciousness, 91 Neurology 471, 471–75 (2018).}
\textsuperscript{86. Id. at 295 (Scalia, J., concurring).}
\textsuperscript{87. Giacino, The Vegetative and Minimally Conscious States, supra note 43, at 295–97 (explaining that there are “general physiologic responses to pain”).}
\textsuperscript{88. Id. at 294.}
\textsuperscript{89. Cerminara & Johnson, supra note 67.}
\textsuperscript{90. See, e.g., Moshe Frenkel, Refusing Treatment, 81 Oncologist 634, 634–35 (2013) (recounting story of Suzanna, a patient who refused chemotherapy).}
\textsuperscript{91. Hastings Ctr., supra note 28, at 59; see also, e.g., Or. Rev. Stat. Ann. § 127.805 (West 2017).}
that existence due to the limitations posed by the minimal nature of the MCS.92

In sum, many variations in the exercise of autonomy may and should become more common if courts see more cases involving life-sustaining treatment decision-making for and with patients in the MCS. With the higher levels of MCS, there may even be a place for supported decision-making, a process intended to preserve whatever remains of the patient’s ability to express himself or herself with some level of capacity.93 Neurology clinicians have spoken of medical decision-making for patients in MCS as “mosaic decision-making,” involving a patchwork of considerations gathered from a variety of resources, including the patient, to the extent possible.94 Increasing understanding of the condition will develop the contours of autonomy in medical decision-making for patients in MCS, implicating both the approaches evident in Cruzan and expanding the amount of information appropriately considered.

IV. FROM DENIAL OF DEATH TO PROTESTS AGAINST ONE TYPE OF DEATH

Nancy Cruzan was in a PVS at the time of her lawsuit.95 Her tombstone reads: “Departed, Jan. 11, 1983; At Peace, Dec. 26, 1990.”96 In November 1990, a reporter described her as having died in 1983 “at a time and in a place that [did] not recognize her death.”97

Legally, of course, Ms. Cruzan was not dead until December 26, 1990; her case revolved around the question of whether doctors legally could withdraw her medically supplied nutrition and hydration so that she could die.98 A person in a PVS is not legally dead; in every state in this country, the law provides that physicians may declare death only when (1) the patient ceases respiration and circulation (known as “cardiac death”) or (2) the patient’s entire brain, including the brainstem, has ceased functioning (known as “death by neurological criteria” or “brain death”).99

Brain death does, however, present an intriguing puzzle when considering its interaction with autonomy. While one might normally think that

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92. Johnson, The Right to Die in the Minimally Conscious State, supra note 65, at 175.
97. Id. (quoting Richard Momeyer, Finally, Let’s Admit Nancy Cruzan Is Dead, NEWS-DAY, Apr. 16, 1990, at 43).
“death is death,” it actually is a social construct, a societal judgment involving far more than medicine. The factors other than medicine involved in determining death imply that a person’s choice should play a role in whether to be dead.

A. Death as a Social Construct

Brain death has a fifty-year history in the United States. In 1968, an ad hoc committee at the Harvard Medical School (the Committee) took various medical and social factors into account in determining that it was medically appropriate for physicians to declare people dead when all portions of their brain had ceased functioning. Improvement in cardiopulmonary resuscitation techniques and respiratory support had increased the number of people with no brain function occupying hospital beds. Moreover, the Committee said, “Obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation.”

Among the public, confusion and much debate surround brain death. It is easy, if painful, to understand that a person is dead when he or she is not breathing, but both patients in the PVS who lack only higher brain function and patients with no brain function breathe and appear to be in the same condition, thanks to technology. Thus, it is easy for people without medical backgrounds to believe they are the same. While the reporter who described Ms. Cruzan as being dead in 1983 was speaking metaphorically, many families have a hard time telling the difference, given the similar appearance of patients in the two categories. The media compounds the problem by using the names of various neurological diagnoses, including brain death, interchangeably.

Similarly, but for different reasons, medical, ethical, and legal experts have debated the recognition of brain death as legal death from the 1960s through the present day. “Brain death has always been a bit suspect to

100. See Ackerman, supra note 20, at 1579–80.
102. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma, 205 JAMA 337, 337 (1968) (“More than medical problems are present. There are moral, ethical, religious, and legal issues.”).
103. Id.
104. Id.
106. Id. at 169 (“There are for some just too many signs of life, and some may not take the news at face value.”).
107. Momeyer, supra note 97, at 43.
108. Stuart J. Youngner & Elizabeth O'Toole, Withdrawing Treatment in the Persistent Vegetative State, 331 New Eng. J. Medicine 1382, 1382 (1994); cf. In re Quinlan, 355 A.2d 647, 652 (N.J. 1976) (New Jersey Supreme Court took pains to explain that Ms. Quinlan’s PVS was not brain death, emphasizing that Ms. Quinlan was not dead).
109. Kompanje, supra note 105, at 170 (providing examples).
110. See generally Pope, Legal Briefing, supra note 31, at 245 (explaining varying positions among experts while discussing the legal status of brain death).
some, due in part to philosophical and religious objections but also due to its utilitarian roots. 111

In contrast, state legislatures have embraced the concept of brain death. Physicians in all fifty states may declare death based on either cessation of cardiopulmonary functioning or total absence of activity in the entire brain, including the brain stem. 112 The law treats the question of whether a patient is dead as one of fact to be determined by physicians, yet state laws vary in delineating when a physician may declare a patient dead, suggesting that death cannot be determined “by discovering, as an objective, scientific fact of the matter, but rather . . . by deciding, through a social consensus hopefully supported by the most reliable scientific information.” 113

At the time of Cruzan, then, the law had long recognized brain death and did not consider it to be a controversial diagnosis. The tables have turned since Cruzan: brain death sparks great controversy while PVS has become a relatively routine diagnosis underlying refusals of life-sustaining treatment. 114

B. PUSHBACK AGAINST BRAIN DEATH DECLARATIONS

Beginning in the 2010s, brain-death declarations, previously rarely contested, increasingly became the subjects of protests and even litigation. 115 Some were religious objections to the diagnosis. 116 In New York in 2019, for example, a trial court judge required that a hospital vacate a death certificate issued on the basis of brain death when it found that the hospital had failed to reasonably accommodate the religious beliefs of the pa-
Patient’s family. New York regulations governing death by neurological criteria require hospitals to establish and implement written policies about determination of death, including reasonable accommodation of religious or moral objections to the determination. Finding that the hospital had not reasonably accommodated the family’s religious beliefs, “the trial court ordered that they take all steps necessary to vacate the death certificate in question and to arrange for the issuance of a new death certificate showing the date the patient ceased circulatory and respiratory functions instead of the original date.”

Accommodation leads to confusion because it facilitates the existence of a seemingly impossible situation: a person can be dead in one state and not in another. The case of Jahi McMath provides an excellent illustration, beginning with a California declaration that she was brain-dead after a tonsillectomy in 2013. Her family objected to the diagnosis and transferred her body to New Jersey, where the law prohibits declaration of brain death when conscientious objections to the diagnosis exist. Five years later, in 2018, Ms. McMath was pronounced dead after cessation of cardiopulmonary functions, and her family ended the several lawsuits they had filed over her death. One of those lawsuits had sought to invalidate the death certificate in California while Ms. McMath’s body was maintained in New Jersey.

Other objections to brain death may derive from a variety of sources. Some objectors simply may not believe that brain dead is a valid concept. Medical research, for example, has shown that wounds heal, infections are healed, and a fetus may be gestated within the body of a patient who has been declared brain-dead, leaving some to wonder what death means if these activities can take place after its declaration. Others may be concerned about the speed with which patients are declared brain-dead based on publicity accorded medical resource shortages, including shortages of organs for transplantation. Once a patient has been declared dead, there is no duty to continue treatment because “the patient

118. See 10 N.Y. Comp. Codes R. & Regs. tit. 10, § 400.16 (requiring policies and procedures for reasonable accommodation of objections to death by neurological criteria).
119. Meisel et al., supra note 5, § 1A.36, at 1A-254.
120. Id. § 1A.35[E], at 1A-250-51.
121. Id. § 1A.22, at 1A-162; Certificate of Death: Jahi Kelis McMath (Cal. Dec. 12, 2013).
123. Meisel et al., supra note 5, §1A.35[A], at 1A-245 (referring to “the New Jersey death certificate issued in June 2018”); Certificate of Death: Jahi Kelis McMath (N.J. June 22, 2018).
126. Meisel et al., supra note 5, § 1A.35[E], at 1A-250.
is no longer a patient;” instead, it becomes a dead body.127 Dead bodies are sources of organs for transplants, and some families may fear the need for an organ is prompting a conclusion that their loved one is dead even though he or she is rosy-cheeked and breathing, albeit through a ventilator.128

Recent litigation over brain-death protests has moved from objecting to declarations of death, as in the case of Jahi McMath, to refusing consent to the testing required to determine brain death, as in the case of Aiden Hailu out of Nevada.129 In Hailu, a twenty-year-old college student’s death “upended the law of brain death in that state.”130 Nevada law had provided that death be determined “in accordance with [generally] accepted medical standards.”131 The hospital in which Ms. Hailu was a patient first determined that she was not brain-dead after three electroencephalogram (EEG) tests132 but later declared her brain-dead after she failed an apnea test more than a month later.133 Her father, who was her guardian, had objected to the administration of the apnea test and followed up by objecting to the declaration of death and seeking a temporary restraining order preventing the hospital from removing her life support equipment.134

In declaring Ms. Hailu brain-dead, her hospital had used American Association of Neurology (AAN) guidelines, which it argued constituted the generally accepted medical standard.135 The trial court ruled in favor of the hospital because those guidelines were generally accepted medical standards,136 but those guidelines could have resulted (as indeed they did) in a different conclusion from an EEG examination looking for loss of whole-brain activity.137 Therefore, the Nevada Supreme Court re-

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128. Kompanje, supra note 105, at 169–70 (quoting one family member as saying, “I see no difference. He is still breathing and his heart is beating.”); see also In re T.A.C.P., 609 So. 2d 588, 589 (Fla. 1992) (parents seeking declaration of brain death for their anencephalic infant so that they could donate the infant’s organs).
129. See In re Guardianship of Hailu, 361 P.3d 524 (Nev. 2015).
130. MEISEL ET AL., supra note 5, § 1A.25[A], at 1A-196 (stating then that the case had “potentially” done so, but Nevada did indeed amend its brain death statute the following year, as seen in MEISEL ET AL., supra note 5, § 1A.29[C], at 1A-220).
131. NEV. REV. STAT. ANN. § 451.007(2)(a) (West 2017); see also § 451.007; UNIF. DETERMINATION OF DEATH ACT (UNIF. LAW COMM’N 1980).
132. Hailu, 361 P.3d at 525.
133. Id. at 525 n.3 (“An apnea test ‘adds carbon dioxide to the patient’s blood. A person with a functioning brain stem tries to breathe in response to the carbon dioxide. If the patient tries to breathe, you abort the test immediately and say the patient is not brain-dead.’” (quoting LESLIE C. GRIFFIN & JOAN H. KRAUSE, PRACTICING BIOETHICS LAW 106 (2015))).
134. Id. at 525. Thanks to informed consent law, patients’ families may be learning more about the procedures physicians are performing on their loved ones, providing more opportunities for objection earlier in the process. MEISEL ET AL., supra note 5, § 1A.35[E], at 1A-250.
135. Hailu, 361 P.3d at 526.
136. See id. at 527–28.
137. Id. at 527 (A diagnosis of brain death follows the successful completion of a number of prerequisites. They include a clinical evaluation, neurological testing examining the absence of cerebral or brainstem function by testing the patient’s reflexes, as well as imag-
versed, holding that the legislature intended to ensure that the brain was not functioning at all before declaration of death and that the model act upon which the legislature had based its law had sought to achieve uniformity in diagnosis by requiring that determinations of death “be made in accordance with accepted medical standards,” and applied and construed in a manner “uniform among the states which enact it.”

The trial court, the state supreme court ruled, had erred by failing to consider whether AAN guidelines were generally accepted medical standards among all the states that adopted the same model act that Nevada had adopted; only then would they suffice to support a diagnosis of brain death. It remanded the case to the trial court for additional evidence and reconsideration of whether a determination of death using the AAN guidelines would satisfy the state’s statutory test, resulting in legal uncertainty about determining brain death in Nevada.

The Nevada legislature responded by amending its law. The Nevada statute on determination of death now provides as follows:

1. For legal and medical purposes, a person is dead if the person has sustained an irreversible cessation of:
   (a) Circulatory and respiratory functions; or
   (b) All functions of the person’s entire brain, including his or her brain stem.
2. A determination of death made under:
   (a) Paragraph (a) of subsection 1 must be made in accordance with accepted medical standards.
   (b) Paragraph (b) of subsection 1 must be made in accordance with the applicable guidelines set forth in:

Testing such as the electroencephalogram (EEG), the apnea test, and other ancillary diagnostic tests. Only after all other diagnostic criteria have been satisfied may the apnea test be performed. The apnea test is required for the diagnosis of brain death and involves disconnecting the patient from the ventilator and supplying oxygen via a nasal cannula. Any spontaneous respiratory efforts are noted and the partial pressure of arterial carbon dioxide (PaCO2) is measured. Absent visualization of any respiratory efforts and a PaCO2 over 60 mmHg (or in some cases, 20 mmHg over the baseline), the patient meets the criteria for brain death. An EEG is a useful confirmatory test for the diagnosis of brain death that involves connecting electrodes to the scalp and measuring electrical activity in the brain by recording summed synaptic potentials. An isoelectric or flat recording for thirty minutes confirms the diagnosis.); see also Zhe Chen et al., An Empirical EEG Analysis in Brain Death Diagnosis for Adults, 2 COGNITIVE NEURODYNAMICS 257 (2008); DEPT OF SURGICAL EDUC., ORLANDO REG’L MED. CTR., BRAIN DEATH DETERMINATION/APNEA TESTING 1–5, http://www.surgicalcriticalcare.net/Guidelines/brain_death_determination_2009.pdf [https://perma.cc/5ZQM-83CE] (last updated Oct. 10, 2009); G. Bryan Young, Diagnosis of Brain Death, UpToDate, https://www.uptodate.com/contents/diagnosis-of-brain-death [https://perma.cc/YEU8-X8JU] (last updated May 27, 2015).

138. Hailu, 361 P.3d at 532.
139. Id. at 529 (quoting NEV. REV. STAT. ANN. § 451.007(2)–(3) (West 2017)).
140. Id. at 532.
In the new section (2)(b), the legislature specified particular medical guidelines “or any subsequent revision” of them for the medical profession to use in declaring death. In response to that case and the legislature’s action, the AAN has issued a position statement calling for uniform brain death laws, policies, and practices.

Most other states have not amended their laws in the way Nevada has, meaning that here, too, as with accommodation of objections based on conscience, it may be possible to be dead in one state but not in another depending on the medical guidelines used. The resulting lack of specificity and uniformity is a source of concern for the AAN, which states that “[t]he medical profession’s ability to determine death accurately, whether caused by irreversible brain or circulatory failure, is integral to the maintenance of the public trust in the profession’s fulfillment of its fiduciary responsibility to its patients.” In its statement, the AAN emphasizes that preserved neuroendocrine function, which can cause the physical changes after death described earlier, does not invalidate the whole brain standard of death and recommends some measures to enhance public trust and to deal with accommodation requests.

One might ask what protests against declarations of brain death have to do with views of autonomy. If brain death is indeed a social construct, then one might argue that the more expansive view of autonomy requires honoring the conception of death each person chooses in all cases. Such a conclusion suggests that the law and medicine should honor objections to brain-death declarations in many more cases than current practice permits. A decision to recognize neurologists’ definition of death or a more traditional definition of death involves “defin[ing] one’s own concept of existence” in somewhat the same way as a decision to continue or disconnect life-sustaining treatment does. Yet honoring all objections to

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143. Id. § 451.007(b).
144. James R. Russell et al., Brain Death, the Determination of Brain Death, and Member Guidance for Brain Death Accommodation Requests, 92 Neurology 228, 228 (2019); see also Sherri A. Braksick et al., Variability in Reported Physician Practices for Brain Death Determination, 92 Neurology 1, 1 (2019).
145. Russell et al., supra note 144, at 228.
146. Id. at 230–31.
brain-death declarations would go too far because doing so reduces death to the absurd. If the AAN is disturbed by the lack of public trust in brain-death declarations in the current situation, imagine how unmoored and untrustworthy the medical profession would seem if patient families could choose whether they had died.

Instead, limiting actionable objections to those arising from conscience or religion is sensible. The expansive view of autonomy will still require respect for both refusals of consent to apnea testing and protests against a diagnosis of brain death, but autonomy will be limited in the name of state interests in the trustworthiness of the medical profession. In the name of public trust, state interests should overwhelm a person’s asserted right to choose whether to recognize brain death as death except in limited situations.

V. CONCLUSION

In conclusion, this article has identified three situations in which end-of-life decision-making autonomy faces legal development unimaginable at the time of *Cruzan*. Legislatures and courts have been and increasingly will be grappling with the definition of autonomy in instances of voluntarily stopping eating and drinking, refusals of life-sustaining treatment by patients in the MCS, and objections to declarations of brain death.

The Supreme Court since *Cruzan* has adopted two versions of constitutionally protected decision-making, both of which have roots in the *Cruzan* opinions. Justice O’Connor also suggested that constitutionally protecting autonomy in medical decision-making may require honoring a patient’s appointed surrogate’s end-of-life treatment decisions regardless of the strength or weakness of the patient’s wishes. As clinical progress continues, we will see the law of medical end-of-life decision-making autonomy repeatedly invoke *Cruzan* in a broader range of settings. Ms. Cruzan’s legacy in autonomy lives on.